

# STATEMENT FOR MISCELLANEOUS SERVICES

Dept. of Labor and Industries  
Claims Section  
PO Box 44269  
Olympia WA 98504-4269

- ☐ Dental Services  
☐ Medical Equipment/ Prosthetics-Orthotics  
☐ Transportation  
☐ Home Health/ Nursing Home Services
- ☐ Glasses  
☐ Vocational / Retraining  
☐ Other

**DO NOT  
WRITE IN  
SPACE** ➤

Worker's full name Last		First		Middle	SSN (ID only)	Claim Number
Mailing address					Employer's Name	
City			State	ZIP	Reimburse injured worker <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, receipt required
Date of Injury	Name of referring physician or other source				Referring physician provider number	

DIAGNOSIS OR NATURE OF ILLNESS OR INJURY  
(use ICD-9-CM) Designate left or right when applicable

- 1.
- 2.
- 3.
- 4.
- 5.

For glasses, advise if old Rx was available

☐ Yes ☐ No

Give hospitalization date for inpatient services

Admitted \_\_\_\_\_

Discharged \_\_\_\_\_

REFUND CERTIFICATION

I hereby certify under penalty of perjury that this is a true and correct claim for the necessary expenses incurred by me, that the claim is just and due and that no payment has been received by me on account thereof.

CLAIMANT'S SIGNATURE.

FROM DATE OF SERVICE	* POS	TOS	PROC CODE	MOD CODE	Describe procedures, medical services or supplies furnished. Attach lab reports, X-ray findings and any special services	Dental tooth #	Home Nursing No. of hrs/day	Hourly/ Day rate	GLASSES OLD RX OD	NEW RX OD	CHARGES \$	Unit C	T O DATE OF SERVICE
1.													
2.													
3.													
4.													
5.													
6.													
7.													
8.													
9.													
10.													
11.													
12.													
13.													

Submission of this bill certifies the material furnished, service provided, expense incurred or other item of indebtedness as charged in the foregoing bill is a true and correct charge against the state of Washington; that the claim is just and due; that no part of the same has been paid. Signature: _____ Bill date: _____	Provider or Supplier name		Provider number	Total Charge
	Address		Phone Number	
	City	State	ZIP+4	Your Patient's Account Number
	Federal tax ID <input type="checkbox"/> EIN <input type="checkbox"/> SSN			Referral ID
Remarks:				



\* Place of Service (POS) and Type of Service (TOS) codes on page 2

# INSTRUCTIONS FOR COMPLETING MISCELLANEOUS SERVICES FORM

- Place an "X" in the box next to the type of service for which you are billing.
- CLAIM NUMBER:** For the injured worker receiving services.  

INDUSTRIAL INSURANCE	Claim numbers are six digits, preceded by a "B, C, F, G, H, J, K, L, M, N, P, X or Y". Crime Victim claim numbers are six digits preceded by a "V" or five digits preceded by a "VA, VB, VC, VH, VJ or VK". Department of Energy claims are seven digits with no preceding letter.
	Send bills for Industrial Insurance claims to: Department of Labor and Industries PO Box 44269 Olympia WA 98504-4269
	Send bills for Crime Victims claims to: Department of Labor and Industries PO Box 44520 Olympia WA 98504-4520
SELF INSURANCE	Department bill forms are furnished at no charge to the vendor and can be obtained by calling the local department service location. Self-Insurance claim numbers are six digits preceded by an "S, T or W". Bills for all self-insurance claims should be sent directly to the employer or their service company. Department bill forms, self-insured forms, or other forms acceptable to the self-insurer may be used.
- INJURED WORKER'S NAME:** Injured worker's full name, last name first.
- SOCIAL SECURITY NUMBER:** Record claimant's social security number. It is helpful when the claim number is wrong and the worker's name is common.
- ADDRESS:** The injured worker's most current address.
- EMPLOYER'S NAME:** The injured worker's employer's name. If the claim number is in error, this helps identify the proper claim.
- DATE OF INJURY:** This is important and must be included. One worker may have several claims so it is vital the proper claim be identified and charged for services provided. The date of injury positively identifies each claim.
- NAME OF REFERRING PHYSICIAN:** The name of the physician who has referred the claimant to you, the provider, for services. (Not applicable for Vocational Services billing.)
- REFERRING PHYSICIAN PROVIDER NUMBER:** The Department of Labor and Industries provider account number of the referring physician. The number may be obtained from the referring physician. (Not applicable for Vocational Services billing.)
- DIAGNOSIS:** Indicate both the ICD9-CM number and the narrative diagnosis for all conditions treated. Designate left or right side of body, when applicable. The diagnosis presented must be specific. (Not applicable for Vocational Services billing.)
- FOR GLASSES:** Indicate by placing an "X" in the appropriate box.
- SERVICES RELATED TO HOSPITALIZATION:** If claimant was hospitalized, record the date admitted and the date discharged.
- ITEMIZATION OF SERVICES AND CHARGES:**
  - DATE(s) OF SERVICE:** Record the date for each service provided. For consecutive dates of service, (e.g., home care, attendant care, equipment rental, etc.) record both beginning (from-date-of-service column) and ending (to-date-of-service column) dates.
  - PLACE OF SERVICE:** Place of Service (POS) codes are printed below. Please refer to that list and place the appropriate code in the space provided.
  - TYPE OF SERVICE:** A complete list of Type of Service (TOS) codes is printed below. Please refer to that list and place the appropriate code in the space provided.
  - PROCEDURE CODE:** Identifies the procedures used. Procedure codes can be found in the **Medical Aid Rules and Maximum Fee Schedule** distributed by the Department of Labor and Industries.
  - CODE MODIFIER:** A modifier provides the means by which the reporting physician can indicate that a performed service or procedure has been altered by some specific circumstance, but has not changed in its definition or code. When applicable, the modifying circumstance should be identified by the addition of the appropriate "modifier code number" (including the hyphen) after the usual procedure number.
  - DENTAL:** To be used for dental services only.  
**Tooth Number:** Identify dental services provided by placing the specific tooth number in the appropriate box.
  - HOME NURSING:** To be used for home care only  
**Number of Hours or Days:** Identify the number of hours or the number of days that the home care services were provided.  
**Hourly or Daily Rate:** Record the rate charged (by the hour or day) for the home care services provided.
  - GLASSES:** To be used for glasses repair or replacement only.  
Old Rx (OD and OS): If the old prescription is available, specify for both the left and right eyes.  
New Rx (OD and OS): Specify the new prescription for both the left and right eyes.
  - CHARGES:** Charges for services provided.
- PROVIDER'S OR SUPPLIER'S NAME, ADDRESS, ZIP CODE AND TELEPHONE NUMBER:** The provider's or supplier's name and current address. If any of the information changes, notify Provider Accounts immediately. (Indicating a new address on the bill **will not** change the department's record of address for the provider.)
- PROVIDER NUMBER:** Identification number designated by the Department of Labor and Industries for the provider.
- TOTAL CHARGE:** Total of all charges for services provided.
- YOUR PATIENT'S ACCOUNT NUMBER:** The number used to identify your patient's account.
- REFERRAL ID:** Enter the referral ID.
- REMARKS:** Any information necessary that the provider or supplier feels is necessary for further explanation.

## ATTACHMENTS

The following attachments **must be** submitted with billings for appropriate services:

- |                   |                      |                             |                                       |
|-------------------|----------------------|-----------------------------|---------------------------------------|
| 1. X-ray findings | 3. Office Notes      | 5. Emergency Room reports   | 7. Cost invoice of supplies furnished |
| 2. Lab reports    | 4. Operative reports | 6. Diagnostic Study reports | 8. Consultation reports               |

Each attachment must have the corresponding claim number listed in the upper right corner of the attachment.

**DUE TO THE FACT THAT THE DEPARTMENT RECORDS ARE KEPT ON MICROFILM, BILLS AND ATTACHMENTS MUST BE LEGIBLE AND CLEAR.**

The following attachment **is not** acceptable: Office Visit Slips.

## REBILLS

If you do not receive payment or notification from the department within ninety (90) days, services may be rebilled. Rebills should be identical to the original bill: same charges, codes and billing dates. Please indicate "Rebill" on the bill.

Any inquiries regarding adjustment of charges must be submitted within ninety (90) days from the date of payment to be considered.

### TYPE OF SERVICE (TOS)

C Chiropractic Services	P Physical Therapy	4 Dental
D Drugless Therapeutics	V Vocational Services	9 Ancillary Services
N Nurse Practitioner Services	3 Medical Services	(attendant, equipment, glasses)

### PLACE OF SERVICE (POS)

01. Office	31. Skilled Nursing Facility	54. Intermediate Care Facility/Mentally Retarded
03. School	32. Nursing Facility	55. Residential Substance Abuse Trmt Facility
04. Homeless Shelter	33. Custodial Care Facility	56. Psychiatric Residential Trmt Ctr
05. Indian Health Service	34. Hospice	60. Mass Immunization Ctr
Free-standing Facility	41. Ambulance - Land	61. Comprehensive Inpatient Rehabilitation Facility
06. Indian Health Service	42. Ambulance - Air or Water	65. End Stage Renal Disease Trmt Facility
Provider-based Facility	50. Federally Qualified Hlth Ctr	71. State or Local Public Health Clinic
07. Tribal 638 Provider-based Facility	51. Inpatient Psychiatric Facility	72. Rural Hlth Clinic
	52. Psychiatric Facility Partial Hospitalization	81. Independent Laboratory
	53. Community Mental Health Ctr	99. Other Unlisted Facility
21. Inpatient Hospital		
22. Outpatient Hospital		
23. Emergency Rm - Hospital		
24. Ambulatory Surgical Ctr		
25. Birthing Ctr		
26. Military Trmt Facility		